



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

VISTA HOSPITAL OF DALLAS  
4301 VISTA RD  
PASADENA TX 77504-2117

#### **Respondent Name**

DALLAS NATIONAL INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 20

#### **MFDR Tracking Number**

M4-09-B153-01

#### **MFDR Date Received**

August 5, 2009

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Carrier has severely under-reimbursed Provider by either applying the inappropriate reimbursement methodology or inappropriately calculating reimbursement under the applicable rule."

**Amount in Dispute:** \$11,254.86

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Contrary to Requestor Vista Hospital of Dallas' allegations, Respondent has made a valid and legal reimbursement, denial or reduction of fees, under the Texas Department of Insurance, Division of Workers' Compensation (DWC) medical fee guidelines, rules and statutes. . . . Additionally, ComplQ reduced the bill based on a PPO discount."

**Response Submitted by:** Lewis & Backhaus, PC, 14160 Dallas Parkway 400, Dallas, Texas 75254

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 5, 2008	Outpatient Hospital Services	\$11,254.86	\$9,456.35

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 176 – Modifier 27 / TC represents the technical component of services performed
  - 222 – Charge exceeds Fee Schedule allowance
  - 785 – Items and/or services are packaged into APC rate. Therefore there is no separate APC payment.
  - 788 – Significant procedure. Multiple procedure reduction applies.
  - 881 – This item is an integral part of an emergency room visit or surgical procedure and is therefore included
  - 97 – Payment is included in the allowance for another service/procedure.
  - W1 – Workers Compensation State Fee Schedule Adjustment.
  - 45 – Charges exceed your contracted/legislated fee arrangement.
  - P32 – PPO Reductions based on agreement with First Health

### **Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

### **Findings**

1. The insurance carrier reduced or denied disputed services with reason codes P32 – “PPO Reductions based on agreement with First Health,” and 45 – “Charges exceed your contracted/legislated fee arrangement.” Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 14, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support that the health care provider had been given notice, in the time and manner required by §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time of the disputed dates of service. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables in accordance with subsection (g). Review of the submitted documentation finds that separate reimbursement for implantables was requested; however, §134.403(g)(1) requires that a provider billing separately for an implantable “shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: ‘I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.’” Review of the submitted billing documentation finds no such certification. The Division concludes that the facility has not requested separate reimbursement of implantables in accordance with subsection (g). Separate payment of implantables is not recommended; therefore, the applicable rule for reimbursement is §134.403(f)(1)(A). Accordingly, the Medicare facility specific reimbursement including outlier payments shall be multiplied by 200 percent.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code A4649 represents an item or service for which payment is bundled into payment for other services billed on the same date of service. Separate payment is not recommended.
- Procedure code A4649 represents an item or service for which payment is bundled into payment for other services billed on the same date of service. Separate payment is not recommended.
- Procedure code 82948 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.43. This amount multiplied by 2 units is \$8.86. 125% of this amount is \$11.07. The recommended payment is \$11.07.
- Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 42, which, per OPPS Addendum A, has a payment rate of \$2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,746.76. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of \$1,709.38. The non-labor related portion is 40% of the APC rate or \$1,164.51. The sum of the labor and non-labor related amounts is \$2,873.89. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$2,873.89 divided by the sum of all S and T APC payments of \$5,215.64 gives an APC payment ratio for this line of 0.551014, multiplied by the sum of all S and T line charges of \$10,384.00, yields a new charge amount of \$5,721.73 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of \$5,721.73 yields a cost of \$1,865.28. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$2,873.89 divided by the sum of all APC payments is 55.10%. The sum of all packaged costs is \$4,182.18. The allocated portion of packaged costs is \$2,304.44. This amount added to the service cost yields a total cost of \$4,169.72. The cost of these services exceeds the annual fixed-dollar threshold of \$1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total APC payment for this line is \$2,873.89. This amount multiplied by 200% yields a MAR of \$5,747.78.
- Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 42, which, per OPPS Addendum A, has a payment rate of \$2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,746.76. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of \$1,709.38. The non-labor related portion is 40% of the APC rate or \$1,164.51. The sum of the labor and non-labor related amounts is \$2,873.89. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$1,436.95 divided by the sum of all S and T APC payments of \$5,215.64 gives an APC payment ratio for this line of 0.275508, multiplied by the sum of all S and T line charges of \$10,384.00, yields a new charge amount of \$2,860.88 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed

charge of \$2,860.88 yields a cost of \$932.65. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$1,436.95 divided by the sum of all APC payments is 27.55%. The sum of all packaged costs is \$4,182.18. The allocated portion of packaged costs is \$1,152.22. This amount added to the service cost yields a total cost of \$2,084.87. The cost of these services exceeds the annual fixed-dollar threshold of \$1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total APC payment for this line, including multiple-procedure discount, is \$1,436.95. This amount multiplied by 200% yields a MAR of \$2,873.90.

- Procedure code 29824 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 41, which, per OPPS Addendum A, has a payment rate of \$1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,099.88. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of \$1,076.34. The non-labor related portion is 40% of the APC rate or \$733.25. The sum of the labor and non-labor related amounts is \$1,809.59. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$904.80 divided by the sum of all S and T APC payments of \$5,215.64 gives an APC payment ratio for this line of 0.173478, multiplied by the sum of all S and T line charges of \$10,384.00, yields a new charge amount of \$1,801.40 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this line, including multiple-procedure discount, is \$904.80. This amount multiplied by 200% yields a MAR of \$1,809.60.
  - Per Medicare policy, procedure code 2999 is not a recognized billing code. Review of the submitted information finds that the documentation does not support reimbursement for the service as billed. Payment cannot be recommended.
  - Procedure code 99144 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Per Medicare policy, procedure code 94762 is a component service of procedure code 99144 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
  - Per Medicare policy, procedure code 99205 is a component service of procedure code 99144 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
  - Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
4. The total allowable reimbursement for the services in dispute is \$10,442.35. This amount less the amount previously paid by the insurance carrier of \$986.00 leaves an amount due to the requestor of \$9,456.35. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$9,456.35.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$9,456.35, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### Authorized Signature

_____	<u>Grayson Richardson</u>	<u>February 27, 2013</u>
Signature	Medical Fee Dispute Resolution Officer	Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**